DCH/LMD-501 (03/04)

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF A MEDICAL SCHOOL LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, MUST SUBMIT THE FOLLOWING:

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of $170.00, made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed 5 times, with no extensions available.

2. Certification of medical education submitted directly from the medical school to the Board on the proper form (attached).

3. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.

4. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other states(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

EDUCATIONAL LIMITED LICENSE APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST SUBMIT THE FOLLOWING:

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of $170.00, made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed 5 times. No extensions are available.

2. Certification of medical education submitted directly from the medical school to the board on the proper form (attached).

3. Certification of appointment to a Michigan training hospital to be completed, on the proper form (attached) and submitted directly to the board by the hospital in which the training is to occur.

4. Certification of having passed examinations in the basic and clinical medical sciences conducted by the Educational Commission for Foreign Medical Graduates.

5. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other states(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

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APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
C.S. License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **Educational Limited and Controlled Substance Fee: 170.00**
71-43-01-375705

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Previous MI License Number and Expiration Date, If applicable

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)

Have you ever held a health professional license in Michigan?

☐ Yes ☐ No

Name of Training Hospital

Street Address of Training Hospital

City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ **Yes**	☐ **No**
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ **Yes**	☐ **No**
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ **Yes**	☐ **No**
4. Have you been treated for substance abuse in the past 2 years?	☐ **Yes**	☐ **No**
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ **Yes**	☐ **No**
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ **Yes**	☐ **No**
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ **Yes**	☐ **No**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets **if necessary**.

Name and Address of Institution	Dates of Attendance From	To	Degree

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II ON PAGE 2 OF THIS FORM.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board Medicine at the address shown on page 1 of this form.

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Name of Training Hospital

Street Address of Training Hospital

City, State and ZIP Code

I certify that _____ **has been duly**

appointed to a training program in the clinical area of _____

_____,

beginning _____ **and ending** _____,

Month/Day/Year Month/Day/Year

at _____.

Name of Training Hospital

Is this program accredited by ACGME? ☐ YES ☐ NO

Is this hospital or institution accredited by JCAH? ☐ YES ☐ NO

_____ _____

Signature of Director of Medical Education Date of Signature

(S E A L)

_____

Print or Type Name of Director of Medical Education

If hosptial has no seal, please indicate.

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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF FOREIGN MEDICAL SCHOOL GRADUATES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission		Date of Graduation

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School
Street Address of Medical School
City, State and ZIP Code

I certify that _____ attended the
(Applicant's Name)

medical school named above from _____ to _____,
Month/Day/Year Month/Day/Year

and was granted the degree of _____ on

_____ .
Month/Day/Year

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences and clerkships in the completed at the hospitals or institutions listed below.

Clinical Sciences	Name and Address of Hospital	Teaching Hospital
Internal Medicine		☐ Yes ☐ No
General Surgery		☐ Yes ☐ No
Pediatrics		☐ Yes ☐ No
Obstetrics and Gynecology		☐ Yes ☐ No
Psychiatry		☐ Yes ☐ No

_____ _____
Signature of Dean or Registrar Date of Signature

_____ (S E A L)
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Date of Admission	Date of Graduation

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

Street Address of Medical School

City, State and ZIP Code

I certify that _____ **attended the**
(Applicant's Name)

medical school named above from _____ **, to** _____ **,**
Month/Day/Year Month/Day/Year

and was/will be granted the degree of _____ **on**

_____ .
Month/Day/Year

_____ _____
Signature of Dean or Registrar Date of Signature

(S E A L)

_____
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.